

Tamarac Secondary School requires an Athletic Health History form be completed for each student athlete. This form is only required to be filled out once and will remain on file for the athlete's entire school career.

Physical will be conducted on:  
 Date \_\_\_\_\_  
 Time \_\_\_\_\_

Grade \_\_\_\_\_

**ATHLETIC HEALTH HISTORY**

SCHOOL NAME: \_\_\_\_\_

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_

Participation in athletics is voluntary and is not a required part of the regular physical education program.

**SPORTS ACTIVITIES**

Identify any sports in which you do not wish your child to participate:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL HEALTH OFFICE AS SOON AS POSSIBLE**

**HEALTH HISTORY  
 TO BE COMPLETED BY PARENT**

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	Elevated Blood Pressure	<input type="radio"/>	<input type="radio"/>
Bee Sting Allergy	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Head Injury/Concussion	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Heart Problem/Murmur-Chest pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Nose Bleeds/Frequent or Severe	<input type="radio"/>	<input type="radio"/>
Bladder/Kidney Problem or Injury	<input type="radio"/>	<input type="radio"/>	Ankle Injury	<input type="radio"/>	<input type="radio"/>
Convulsions/Seizures	<input type="radio"/>	<input type="radio"/>	Back Pain/Injury	<input type="radio"/>	<input type="radio"/>
Fainting Spells	<input type="radio"/>	<input type="radio"/>	Fracture-Dislocation Bones/Joints	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Knee Pain/Injury	<input type="radio"/>	<input type="radio"/>
Ear Problems/Hearing Loss	<input type="radio"/>	<input type="radio"/>	Neck Injury	<input type="radio"/>	<input type="radio"/>
Eye Problems/Vision Loss	<input type="radio"/>	<input type="radio"/>	Nose Fracture	<input type="radio"/>	<input type="radio"/>
Injury to the Spleen	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Joint Sprain/Ligament Tear/Muscle Pullo	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>	<input type="radio"/>

	YES	NO
Is there a current medical examination on file in the nurse's office:	<input type="radio"/>	<input type="radio"/>
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	<input type="radio"/>	<input type="radio"/>
Has your child been unconscious or lost memory from a blow on the head?	<input type="radio"/>	<input type="radio"/>

Does your child have any of the following:	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes.....	<input type="radio"/>	<input type="radio"/>
Severe hearing loss in both ears.....	<input type="radio"/>	<input type="radio"/>
One kidney.....	<input type="radio"/>	<input type="radio"/>
One testicle.....	<input type="radio"/>	<input type="radio"/>
Has your child been ill for five (5) consecutive days?.....	<input type="radio"/>	<input type="radio"/>

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? \_\_\_\_\_  YES  NO

Is your child under medical care now?.....  YES  NO  
 Has your child taken any medication in the past year?.....  YES  NO  
 If so, why? \_\_\_\_\_

Is your child taking any medications now?.....  YES  NO  
 If so, why? \_\_\_\_\_

Has your child ever fainted during exercise?.....  YES  NO  
 If so, explain. \_\_\_\_\_

Has there ever been sudden death in a family member under fifty (50) years of age?.....  YES  NO

Do you have any worries about your child's health or other questions you would like to discuss with a doctor?.....  YES  NO

Does your child have: orthodontic appliances?.....  YES  NO

Capped teeth?.....  YES  NO

Wear contact lenses for sports?.....  YES  NO

Wear glasses for sports?.....  YES  NO

Since your child's last physical examination, has your child had any injury or illnesses?..  YES  NO

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_